Helping Montana seniors and their families make informed decisions on Medicare

MONTANA

Consumer's Guide to Medicare Supplement Insurance

MONTANA STATE AUDITOR
JOHN MORRISON
COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES
Protecting Montana's Consumers

Montana State Auditor's Office ♦ 840 Helena Ave. ♦ Helena, MT 59601 ♦ 406-444-2040 ♦ 800-332-6148 ♦ www.sao.mt.gov

Montana State Auditor
John Morrison

John Morrison was elected Montana State Auditor, the Commissioner of Insurance and Securities in November 2000 and was re-elected in 2004. One of his top priorities as State Auditor has been to increase the accessibility and affordability of all types of insurance for Montana families through legislative and regulatory efforts. He has worked to protect Montana's consumers while maintaining a competitive insurance market.

MONTANA STATE AUDITOR
JOHN MORRISON

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

Dear Montana Consumer,

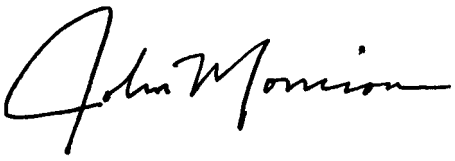
I am pleased to provide you with a copy of the Montana Buyer's Guide to Medicare Supplement Insurance. This guide includes tips on choosing a Medicare supplement, the current coverages provided by Medicare and a chart comparing many of the Medicare supplement policies sold in Montana.

Federal and state regulations require insurance companies to provide Medicare supplement policies that are limited to no more than 14 standard benefit plans. Each of the 14 plans must cover specific expenses. This guide will make it easier for you to compare plans and premiums.

In 2006, Medicare has made some major changes including the introduction of Medicare Part D. If you currently have a Medicare Supplement Plan H, I or J, please discuss your options with your agent or call my office for assistance.

As you use this guide, please keep in mind that it is just that, a guide, to assist you with your purchasing decision. Shop carefully, take your time and contact our office if you have questions. Our Policyholder Services Division has extremely knowledgeable staff members who are dedicated to assisting you with a wide range of insurance questions or problems. Our toll-free number is 1-800-332-6148. Helena residents may reach us at 444-2040.

Sincerely,



Montana State Auditor and
Insurance Commissioner

Montana Consumer's Guide to Medicare Supplement Insurance

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Introduction

The Montana Buyer's Guide to Medicare Supplement Insurance is a joint effort of the Montana Insurance Department and the State Health Insurance Assistance Program (SHIP) to assist seniors in understanding Medicare and Medicare supplement insurance.

What is Medicare?
Medicare is the federal government program that gives you health care coverage if you are age 65 or older, or have a disability, and are a US citizen or have been a permanent legal resident for at least 5 continuous years, regardless of your income. Medicare is divided into two parts: Part A and Part B.

Medicare Part A covers inpatient hospital, skilled nursing facility, home health care and hospice care.

Medicare Part B covers almost all reasonable and necessary medical services, including doctors' services, laboratory and x-ray services, durable medical equipment (wheelchairs, hospital beds etc.), ambulance services, outpatient hospital care, home health care, blood and medical supplies.

Medicare Part C is called "Medicare Advantage" and is an optional plan that will combine all the benefits of Medicare Parts A & B, as well as prescription drug coverages and may provide some or all of the benefits previously available through a standardized Medicare supplement plan. These Medicare Advantage Plans may be "Managed Care" type plans such as HMO, PPO, or Private Fee for Service plans.

Medicare Part D is the optional Medicare Prescription Drug coverage and makes coverage for prescription drugs available to all people with Medicare.

What is a benefit period?
A benefit period begins on the first day of a Medicare-covered inpatient stay. It ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days. A new benefit period begins and the beneficiary must pay a new inpatient hospital deductible. There may be as many as five benefit periods in a calendar year.

Will Medicare cover all medical expenses?
No. Medicare only covers a portion of health care costs. A Medicare supplement helps with expenses not fully paid by Medicare.

Do supplements cover all charges Medicare doesn't?
No. Supplements will not cover expenses if Medicare doesn't pay a portion of the bill, with some exceptions. See the chart on page 11 under Plans F, G, I and J for exceptions.

What if Medicare considers a service to be unnecessary?
If physicians recommend a procedure that they are (or should be) aware is not covered by Medicare, they are required to notify you in writing that Medicare will not cover the service. Similarly, if a surgeon does not accept assignment for elective surgery, the physician must give you a written estimate if the charge will exceed $500.

What is assignment?
It is the acceptance of the charges allowed by Medicare as payment in full.

What is limiting charge?
Physicians who do not accept assignment are limited to charging 115 percent of the fee schedule for nonparticipating doctors.

What is issue age?
The premium is established when you buy your policy. You continue to pay the premium required of a person who is the same age you were when you bought your policy. For example, if you buy a policy at age 65, you always will pay the rate that the company charges people who are 65, regardless of your age.

What is the attained age?
The premium is based on your current age and increases automatically as you grow older. Typically, these plans are less expensive for younger individuals, but may cost considerably more in later years.

Can I be eligible if I'm under 65?
A person can qualify for Medicare under age 65 if they meet certain criteria for disability. If you receive continuing dialysis for permanent kidney failure or need a kidney transplant you could be eligible for Medicare. If you are disabled and have been receiving Social Security Disability payments for at least 2 years or if you have Amyotrophic Lateral Sclerosis (ALS - Lou Gehrig's disease) you could also be eligible for Medicare.

How do I know how much coverage to buy?
It is important to know how to assess your need for insurance in every type of coverage you buy. With a Medicare supplement policy, you should review your medical care costs for the preceding year, assess your current health status and choose a plan that is affordable. You may want to consider enrolling in a Medicare Part D plan if you currently are taking medications. The cost of prescription drugs has increased dramatically in the last few years.

Medicare Savings Programs

The Qualified Medicare Beneficiary Program and Spousal Impoverishment Program are available to assist seniors. These are important benefits if you have limited income and assets or if your spouse is in a long-term care facility.

The Qualified Medicare Beneficiary Program is designed to provide Medicare premiums, deductibles and coinsurance for seniors with limited incomes. The federal government sets the income level for individuals and couples each year. To find out if your income qualifies, contact the Human Resources office in your county. This program will not pay for expenses that Medicare does not allow.

You may suspend your Medicare supplement policy upon enrollment in the Qualified Medicare Beneficiary Program. You will need to notify your insurance company in writing of your eligibility within 90 days. If you lose your eligibility for the beneficiary program, you may reactivate your Medicare supplement policy by notifying the insurer in writing and paying the premium within 90 days of the termination of your eligibility.

The Specified Low Income Beneficiaries Program assists individuals with slightly more income than those who are Qualified Medicare Beneficiaries by paying their Part B premiums each month. Individuals and couples with monthly income in a range specified by the federal government qualify. In addition to the income limit, financial resources including bank accounts, stocks and bonds cannot exceed $4,000 for an individual or $6,000 per couple.

Under the Spousal Impoverishment Program, when a spouse enters a long-term care facility, there are rules for the division of the couple's assets. The spouse at home may retain a maximum of half the couple's resources, not to exceed a maximum set by the federal government. Certain assets are exempt, including the home, household goods and one car. There are regulations concerning the amount of income the spouse at home may retain on a monthly basis. Either spouse may request an assessment of resources when one spouse enters a nursing home. You will need to contact your county welfare office for more information or the State Aging Services Bureau at (406) 444-4077 or 1-800-551-3191.

Preventative Health Benefits

All newly enrolled Medicare beneficiaries will be covered for certain potentially life saving preventative benefits. These benefits include an initial preventative physical examination which includes baseline measurement of height, weight and blood pressure, an electrocardiogram, education counseling and referral related to other Medicare-covered preventative services, such as vaccinations, screening mammography, pap smears and pelvic exams and prostate and colon cancer screening as well as blood tests required for cardiovascular screening, Glaucoma screening and diabetes screening, medical nutritional therapy with no deductible or co-pay.

Open Enrollment

Insurance companies that sell Medicare supplement insurance are required to issue policies to seniors who qualify for Medicare Part B because they have reached age 65, without regard to their current health status. This open enrollment period lasts six months beginning with eligibility for Part B of Medicare.

Companies may not refuse to issue a Medicare supplement to you or delay the issue of the policy based on your medical condition, health status, claims experience or receipt of health care. The company may impose a six-month pre-existing condition clause during the first six months of the policy.

If you delay enrollment in Part B of Medicare and are covered by a plan provided by your or your spouse's employer, you will have an open enrollment period starting with the month in which you no longer are covered by the employer's plan. Your open enrollment period will start when your Part B coverage becomes effective.

If you miss your open enrollment period, contact your local Social Security Office. There may be a waiting period for coverage and premium payments due. Some individuals are eligible for Medicare due to a disability and are under age 65. The open enrollment period applies to these individuals upon turning 65.

The initial open enrollment period for Medicare Part D for all people with Medicare began November 15, 2005 and will continue through May 15, 2006. There will be an annual opportunity for those wishing to change their Medicare Part D plan without prejudice. Every year, if you wish, you may change your Part D plan between November 15th and December 31st. If you are just coming into the Medicare system, you will have open enrollment for a Part D plan that coincides with the open enrollment period for Medicare Part B.

If you do not have coverage for prescription drugs through a current health plan such as a retiree plan from a former employer or a Medicare Advantage Plan with a drug benefit, you should consider enrolling in Medicare Part D. If you do not have other credible drug coverage and do not enroll in a Medicare Part D plan when you are first eligible, you may be subject to substantial late enrollment penalties.

If a person chooses to enroll in a Medicare Advantage Plan for the first time and within the first 12 months that person decides they no longer want to be in that plan, they may, within that first 12 months, return to "traditional" Medicare and a Medicare Supplement policy without prejudice or the application of elimination periods for pre-existing conditions.

Part B Charges

Health care providers are required to bill Medicare directly for beneficiaries. Amounts billed on Part B of Medicare may not exceed 115 percent of the Medicare allowable amount. The law requires physicians to refund charges over 115 percent within 30 days.

Medicare Coverages

Medicare Hospital Insurance – Medicare Part A
Medicare pays for all but $952.00 of your hospital stay during each benefit period for reasonable and necessary care in the first 60 days of confinement. For the next 30 days, it pays all but $258.00 a day for covered services. Medicare pays expenses in excess of $476.00 a day during the 91st through 150th days. These are Lifetime Renewable Days and may be used only once. If you are hospitalized more than 150 days, Medicare pays nothing.

A benefit period begins the first day of hospitalization and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. It is possible to have more than one benefit period and more than one hospital deductible in a calendar year.

Charges for skilled nursing facility stays may be paid by Medicare if the facility is a Medicare-certified facility. To qualify for this benefit, you must have been hospitalized for at least three days and have been admitted to the nursing facility within 30 days of discharge from the hospital. The first 20 days are covered at 100 percent provided you are receiving skilled care. The next 80 days Medicare pays amounts more than $119.00 a day. Beyond the 100th day, Medicare pays nothing.

Under certain conditions, home health care is available for homebound beneficiaries. This coverage includes skilled nursing services, occupational therapy, and physical and speech therapy if provided by a Medicare-certified home health service and if determined to be medically necessary. If your physician establishes a care program that requires durable medical equipment, Medicare will pay 80 percent of the Medicare-approved cost of the equipment. Call 1-800-899-7095 for more information.

Medicare provides coverage for hospice care for patients certified as terminally ill. This benefit is divided into two 90-day hospice benefit periods and one 30-day benefit period. A subsequent extension also may be covered.

You pay for the first three pints of blood and Medicare pays for any additional blood.

Medicare Medical Insurance - Medicare Part B
Medicare covers physician services, outpatient hospital services, lab services, X-ray, radiation and therapy services, home health visits, physical therapy, speech pathology services, some forms of vaccinations, durable medical equipment, limited ambulance services, prosthetic devices, immunosuppressive drugs for the first year following an organ transplant, and other medical supplies and equipment.

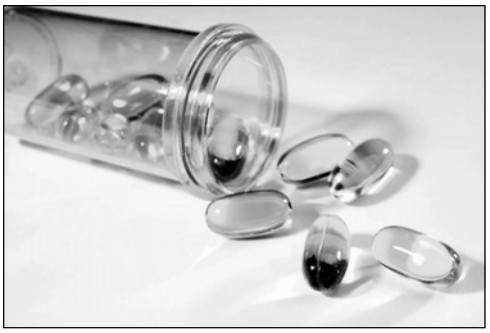
In 2006, the Part B premium is $88.50 a month. You are not required to purchase Part B, but it is an excellent buy because the federal government pays most of the actual cost.

The Part B deductible is the first $124.00 of expenses in a calendar year. After the deductible, Medicare pays 80 percent of the approved charges.

The Medicare deductible for blood expense is the cost of the first three pints.

Medicare Advantage Plan – Medicare Part C
Medicare Advantage Plans offer an alternative to "traditional" Medicare plus a Medicare Supplement policy. Medicare Advantage plans will act as a single servicing point for Medicare for Medicare Parts A & B billing functions. These plans can operate as PPO (preferred provider organization), Managed Care Plan, HMO, Private Fee for Service plan, or as a Specialty plan as approved by Medicare. Under a Managed Care, PPO or HMO type plan, you may have to use doctors and hospitals that are in that plan network or you may have to pay a larger co-pay or other charges if you choose a medical provider that is not a member of your plan. A company that offers Medicare Advantage plans may offer coverage with a national, regional or local service area. Medicare Advantage Plans may include a prescription drug plan equal to or better than a standard Medicare Part D plan or they may require participants to enroll in a separate Medicare part D plan.

Medicare Prescription Drug Program - Medicare Part D
All people with Medicare are eligible to enroll in plans that cover prescription drugs. The premium for this coverage will range from less than $5 per month to about $99 per month and there may be an annual deductible of up to $250. All plans must offer at least the minimum standard benefits as set forth by Medicare but may offer significantly more coverage. The Medicare "standard" benefit states – after your $250 deductible is met, you will pay 25% of your prescription drug costs and Medicare will pay 75% until your total prescription drug cost reach $2250. You will then pay 100% of your prescription drug costs until your total prescription drug costs reach $5100. After your total prescription drug costs reach $5100 you will pay a 5% co pay per prescription and Medicare will pay the remaining 95%.

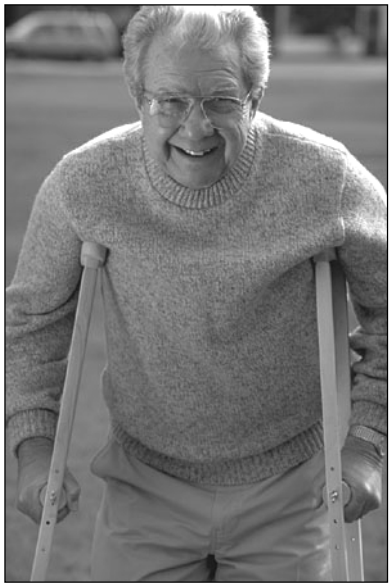


For assistance in choosing the Medicare Part D plan that best suits your needs, you can log onto www.medicare.gov and use the helpful "Plan Finder" link located there or call your local Montana SHIP (State Health Insurance Assistance Program) at 1-800-551-3191 for assistance.

The Medicare Prescription Drug benefit will include additional assistance for people with lower incomes. Most significantly, people with Medicare who are also eligible for Medicaid will receive full premium subsidy, full subsidy of the deductible and minimal co-pays, usually between $2-$5 per prescription. There is also additional assistance available through "Big Sky RX" program administered by the State of Montana, 1-866-369-1233. Other people with Medicare with lower incomes may receive premium and deductible assistance and/or have limited co-pay from either Social Security or Big Sky RX. Please don't hesitate to call the Montana Insurance Department at 1-800-332-6148 or call the Montana SHIP (State Health Insurance Assistance Program) at 1-800-551-3191.

New for 2006 – Medicare Supplement Plans K & L
Beginning in January of 2006, there will be 2 new Medicare Supplement Plans available. These Plans will be titled K & L.

Plan K:
A person who chooses a Medicare Supplement Plan K will have a 50% co-pay for Medicare eligible expenses including your Part A deductible, skilled nursing co-insurance, your first three pints of blood, hospice care, and Part B deductible until such time as your "Out of Pocket" expenses reach $4000 (for 2006). After a person reaches their out of pocket expense threshold, Plan K will pay 100% of Medicare eligible expenses.



Plan L:
A person who chooses Medicare Supplement Plan L will have a 75% co-pay after their deductible is met until their "Out of Pocket" expenses reach the Plan L threshold of $2000 (for 2006). After out of pocket threshold is reached, Plan L will pay 100% of Medicare eligible expenses. The 75% co-pay applies to Medicare Part A & B deductibles as well as skilled nursing care co-insurance, your first 3 pints of blood and hospice care.

Both Plans K & L include coverage for an additional 365 days of inpatient hospital care after other Medicare benefits are exhausted. The "Out of Pocket" thresholds for both plans K & L are indexed to inflation and may increase over time.

Compare Medicare supplement insurance rates

Log onto the Montana State Auditor's web site for quick and easy comparisons of Medicare supplement insurance rates at www.sao.mt.gov. You may also call us at 1-800-332-6148 to have a comparison guide mailed to you.

If you are under age 65 and on Medicare, call you local State Health Insurance Assistance Program (S.H.I.P.) for more information on rates. SHIP counselors are standing by at 1-800-551-3191.

Medicare Medical Insurance - Medicare Part A

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
HOSPITALIZATION Semi-private room and board, general nursing, and misc. hospital services and supplies.	First 60 days 61st - 90th day 91st - 150th day* Beyond 150 days	All but $952 All but $258 All but $476 Nothing	$952 $258 a day $476 a day All costs
POST HOSPITAL NURSING CARE You must have been in a hospital for at least 3 days and enter a Medicare approved facility within 30 days of discharge.	First 20 days The next 80 days Beyond 100 days	100% of approved amount All but $109 a day Nothing	Nothing $119 a day All costs
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, medical supplies etc.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Available to terminally ill.	If a doctor certifies the need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited during a benefit period if medically necessary.	All but the 1st three pints in a calendar year.	The 1st three pints in a calendar year.

* Lifetime Reserve Days may be used only once.

Medicare Medical Insurance - Medicare Part B

Per calendar year 2006 (premium $88.50)

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSE Physicians' service, in/out patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment etc.	Medicare pays medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$124 deductible and 20% of the approved amount (plus any charge above the approved amount).
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Full cost of services.	Nothing for services.
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, medical supplies etc.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	$100 deductible plus 20% of approved amount.
BLOOD	Unlimited if Medically necessary.	80%of approved amount (after $100 deductible and starting with the fourth pint).	First three pints plus 20% of approved amount for additional pints (after $100 deductible).*

* To the extent that the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

14 standard Medicare supplement benefit plans

Core Benefits	A	B	C	D	E	F	F*	G	**H	**I	**J	**J*	K	L
Part A Hospital (Days 61 - 90)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lifetime reserve (Days 91 – 150)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
365 Life Hospital Days 100%	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X	X	X	50%	50%
Part B Coinsurance 20%	X	X	X	X	X	X	X	X	X	X	X	X	50%	50%
Additional Benefits	A	B	C	D	E	F	F*	G	H	I	J	J*	K	L
Skilled Nursing Facility Care			X	X	X	X	X	X	X	X	X	X	50%	75%
Part A Deductible		X	X	X	X	X	X	X	X	X	X	X	50%	75%
Part B Deductible			X			X	X				X	X		
Part B Excess Charges						100%	100%	80%		100%	100%	100%		
Foreign Travel Emergency	X	X	X	X	X	X	X	X	X	X	X	X		
At-Home Recovery	X	X	X	X	X	X	X	X	X	X	X	X		
Prescription Drugs	X	X	X	X	X	X	X	X	X	X	X	X		
Preventive Care	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare cost-sharing out-of-pocket maximum (once met, plan pays 100% all covered items)													$4000	$2000

Core benefits pay the patient's share of Medicare's approved amount for physician services 20% after a $100 annual deductible, the patient's cost of a long hospital stay ($184/ day for days 60-90, $384 for days 91-150, all approved costs not paid by Medicare after day 150 to a total of 365 days lifetime) and charges for the first three pints of blood not covered by Medicare.

Plans H, I and J will no longer be sold to new policyholders. They will continue to be available to existing policyholders with and without the existing prescription drug benefit. Current policyholders may choose to remain in their existing plan H, I or J, or they may retain the plan without the drug benefit and enroll in Part D, or they may choose to change to a different Medicare supplement plan or enroll in a Medicare Advantage Plan.

*Plans F and J have options called high deductibles, which pay the same or offer the same benefits as Plans F and J after the insured has paid a calendar year ($1,580) deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses reach $1,580. Out-of-pocket expenses for this deductible are expenses that ordinarily would be paid by the policy. These expenses include the Medicare deductibles for Parts A and B, but do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the separate foreign travel emergency deductible.

* Skilled Nursing Facility Coinsurance – For Days 21-100.

Buyer's Checklist

The majority of insurance companies and agents are highly ethical, however, a few are not. Not all of the following activities are illegal or unethical, but if after reviewing this checklist, you think an agent has acted improperly, please contact the Montana State Auditor's office.

1. Did the agent try too hard to convince you of the possibility of you becoming bankrupt, of your plans for retirement being disrupted, or of your savings and that of your children or relative being wiped out because of extended illness?

2. Did the agent lead you to believe he or she was a representative of the Medicare program, Insurance Department or other government agency?

3. Did the agent suggest you drop a policy you already have in order to buy the policy he or she was selling?

4. If you already have purchased a policy from an agent, has that agent changed companies and suggested you change your policies over to one offered by the agent's new company?

5. Did the agent suggest you falsify any information on the policy?

6. Did the agent discourage you from shopping around or checking out the policy thoroughly before deciding whether to buy it? Did he or she make you feel like you had to sign up the same day?

7. Did the agent ask you to pay in cash or make your check out to him or her personally or to the agency, instead of the company?

8. Did the agent fail to explain the policy to you or answer your questions completely?

9. Did the agent complete your health history information on the application exactly as you explained it before you signed the application?

10. Check with a reliable source if you have any questions about the authenticity of any Medicare prescription drug card being offered - before you buy!

If you answered "yes" to any of these questions and if you feel an agent has acted improperly, contact one of our knowledgeable staff members in our Policyholder Services Division to discuss the matter.

Montana State Auditor's Office
Insurance Department, Policyholder Services Bureau
840 Helena Ave., Helena MT 59601
Phone:406-444-2040 or 1-800-332-6148

Shopping Tips

Changes in federal law make it easy to shop for Medicare supplement insurance coverage. Before you start comparing policies, consider these five suggestions:

1. Learn about Medicare's basic coverage and gaps.

2. Study the 14 standard Medicare supplement insurance plans. Decide what coverage would best meet your health needs and financial circumstances.

3. Compare only the policies that meet your needs. Although the benefits are identical for all Medicare supplement insurance plans of the same type, premiums vary widely among companies and so does the potential for premium increases.

4. Consider your alternatives. If you have limited income and assets, you may qualify for free coverage through other government programs. To find out if you qualify call 1-800-332-2272.

5. Contact the state health insurance counseling program for an impartial, free review of your existing coverage. In Montana, the number is 1-800-332-2272.

Don't Be A Victim of Insurance Fraud

Often overlooked, insurance is one of the most costly bills we pay each month. That's why State Auditor John Morrison encourages Montana consumers to keep a watchful eye on your insurance bills. Information is the key to avoiding insurance problems and scams. Consumers are urged to call the State Auditor's Office toll-free at 1-800-332-6148 to confirm whether a policy is legitimate. The Montana State Auditor's Office serves as an objective source of information that can help consumers understand the complexities of insurance coverage.

Common Insurance Schemes:

- Overcharging for premiums.
- Collecting annual premiums but submitting only quarterly payments to insurance companies.
- Not returning refunds from companies to the insured person.

To Avoid Becoming a Victim

- Insist on delivery of documents within 30 days of the application.
- Call the company yourself to confirm coverage.
- Read the documents you receive and ask questions. Make agents and companies reply to inquiries in writing.
- Remember, Medicare will NEVER call or visit your home to solicit personal information such as such as your social security number or your credit card numbers.

If you have questions about your insurance policy or agent, please call the State Auditor's Office at 1-800-332-6148 or in Helena at 444-2040.

Definitions

In order to make a wise purchase, it is important to become familiar with the terms used by Medicare and Medicare supplement policies. You may wish to familiarize yourself with the following terms:

ASSIGNMENT: The transfer by the policyholder of some or all of his or her rights under a policy to another party. If assignment is noted on the claim form, the insurance company will pay the health care provider directly. Medicare assignment means the provider will accept the Medicare-approved amounts for covered services as payment in full. The beneficiary would then be responsible for any unmet deductible applied to the charge, for the co-insurance and for any services that were not approved.

COPAYMENT: Your portion or percentage of a health expense. For example, the insurance would pay 80 cents of every dollar on the provider's charges. You pay the remaining 20 cents. With Medicare, the coinsurance would be based on Medicare-allowable charges.

DEDUCTIBLE: The amount of covered expenses you must pay before benefits become payable by the insurers.

EXCLUSIONS OR LIMITATIONS: Specified conditions, circumstances or services not covered by the policy.

GUARANTEED RENEWABLE: The insurance company agrees to continue insuring you so long as you pay the premium. The company reserves the right to non-renew all contracts in the state.

MEDICARE-ALLOWABLE CHARGES: The amount deemed reasonable by Medicare for a given medical service. Benefits are based on Medicare-allowable charges, which may be less than the provider's charges.

PRE-EXISTING CONDITIONS: A physical condition that existed before the policy became effective. Montana law does not allow Medicare supplement polices to exclude coverage for more than six months after the effective date of the policy on the grounds that a condition existed prior to the effective date of coverage. Companies that replace a Medicare supplement policy must waive the pre-existing waiting period on the replacement policy. If the insured has not completed the waiting period on the first policy, any period of time that was completed must be credited on the new policy. This does not apply to those who have previously not purchased a Medicare supplement policy, those who have not had a policy within the last 31 days or those who have lost or been removed from group coverage within the preceding 63 days.

MEDICARE SELECT POLICY: A policy or certificate that contains restricted network provisions. This type of policy may require you to use hospitals and in some cases, doctors within its network to be eligible for full benefits.

SUPPLEMENTAL (MEDIGAP) INSURANCE: You can buy supplemental coverage that pays for some things Original Medicare doesn't cover, like deductibles, doctor and hospital coinsurance and emergency care outside the country.

Private insurance companies offer this supplemental coverage, often called "Medigap" insurance. You can sometimes continue insurance coverage through a former employer.

Federal regulations mandate that all Medicare Supplement policies offer the same set of benefits. That's why, when deciding what company to buy from, the most important factors to consider are cost and stability.

There are 12 different Medicare Supplement plans, labeled A-J (except in Massachusetts, Minnesota and Wisconsin) Plan A offers the fewest benefits and is usually the least expensive; Plan J offers the most benefits and is usually the most expensive.

All the plans MUST include the following basic benefits:

- Hospital coinsurance coverage
- 365 days of full hospital coverage
- Reimbursement for the 20% of the cost of your medical care that Medicare does not cover.
- The first 3 pints of blood you need each year.

Depending on which Medicare Supplement plan you choose, you can get extra coverage for the expenses that Medicare doesn't cover, such as:

- Hospital deductible
- Skilled nursing facility coinsurance
- Emergency care outside the U.S.
- At home recovery care.
- Part B excess charges
- Preventative care
- Limited Prescription drug coverage (this may change in 2006 when Medicare Part D becomes available.)

** See the chart that details the benefits covered by each plan A-L

Your State Department of Insurance (1-800-332-6148) can give you a list of companies that sell Medigap insurance in your state. You can also call the Montana State Health Insurance Assistance Program or SHIP at (1-800-332-2272).

Insurance Inquiry / Complaint Form

State Auditor John Morrison
Insurance Commissioner
840 Helena Avenue
Helena, Montana 59601
Telephone (406) 444-2040 / Montana Toll Free 1-800-332-6148

If you are experiencing an insurance problem, please complete this form and mail to the address listed above. It often takes several weeks for the Department to complete the review and take appropriate action. You will hear from a Compliance Specialist in writing as soon as the review is complete.

Your Name: _____ Phone #: _____

Address:_____

_____

Date of Birth: _____ Social Security Number: _____

Insurance Company's Name: _____

Policy #: _____ Claim #: _____

Kind of Policy: ❑ Auto ❑ Life ❑ Health ❑ Property ❑ Other: _____

Agent's name: _____ Date of Loss: _____

Please indicate which of the following apply:

My complaint is against: ❑ Company ❑ Agent ❑ Adjuster

❑ The company has unfairly rejected my claim or has not paid the full benefits entitled to me.

❑ The company has delayed processing my claim and now they are not responding to me.

❑ The company has not refunded premium moneys that are due to me.

❑ I believe the company's action of cancellation or non-renewal of my policy is not justified.

Other: _____

Do you have an attorney handling this for you? ❑ Yes ❑ No

Please describe your problem in the space below. If more space is needed, please attach additional sheets. Enclose copies of papers and other correspondence relative to this problem. A copy of this form may be forwarded to the insurance company involved.

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Important Telephone Numbers

Medicaid: 1-800-624-3958 or (406) 442-1837

Medicare eligibility, a new Medicare card or how to apply for Medicare coverage or extra help for Medicare Part D Premium assistance: Call the local Social Security Office listed below or the toll-free number: 1-800-772-1213

Billings	1-800-543-0524
Bozeman	(406) 586-4501
Butte	(406) 723-8246
Glasgow	(406) 228-8272
Great Falls	(406) 761-5703
Havre	(406) 265-5472
Helena	(406) 441-1270
Kalispell	(406) 755-1015
Missoula	(406) 251-1580
Premium problems	1-800-833-6364

State Health Insurance Assistance Program

1-800-551-3191

For questions about:

Medicare Part A
Medicare Part B
Medicare Advantage
Medicare Part D

All Medicare claims for services, equipment or home health care call: 1-800-MEDICARE (800-633-4227) or log onto www.Medicare.gov.

Medicare Part D Plan Finder: log onto www.Medicare.gov.

Montana Insurance Commissioner: For questions about insurance, 1-800-332-6148

Peer Review Organization (PRO) Mountain Pacific Quality Health Foundation: If you think you have a problem with quality of care from a physician or health care professional, call 1-800-497-8232 or (406) 443-4020.

Qualified Medical Beneficiary (QMB): (406) 444-7870

Supplemental Insurance questions for federal employees, 1-800-634-3569 or (406) 791-1400

Travelers Medicare (Railroad Retirement): Your Medicare number will have an alpha character before your Social Security number. 1-800-833-4455

United Mine Workers: 1-800-843-8109

Big Sky RX: 1-866-369-1233

840 Helena Avenue
Helena, MT 59601

Toll-Free Hotline
(outside Helena)
1-800-332-6148
In Helena: 444-2040
Fax: (406) 444-3497
TDD Telephone: (406) 444-3246

Website:
sao.mt.gov

The State Auditor's Office attempts to provide reasonable accommodation for any known disability that may interfere with a person's ability to participate in any service, program or activity of the agency. Alternative accessible formats of this document will be provided upon request. For more information call (406) 444-2040 or TDD (406) 444-3246.

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